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56 Pickering Street Needham, MA 02492 T: (781)453-1166 F: (781)453-1167 www.bailit-health.com

TO: Members of the Special Commission on Provider Price Reform
FROM: Michael Bailit
DATE: July 13, 2011
RE: Stakeholder Input to the Commission

Introduction

In my role as consultant to the Special Commission on Provider Price Reform, I spoke with several stakeholder groups during the weeks preceding the Commission's July 13 meeting. The purposes of these meetings were to:

- educate the stakeholders about the Special Commission on Provider Price Reform, including its statutory basis, purpose, scope and timeline;
- describe the process by which the Special Commission seeks to engage stakeholders, and solicit their input at key junctures in the Special Commission's work;
- solicit perspectives on provider price variation in Massachusetts; and
- invite suggestions regarding potential provider price reform principles and strategies.

In the course of this work I met with members of the following stakeholder groups:

- community health centers;
- consumer advocates;
- health plans;
- hospitals; and
- nurse practitioners.

In addition, I am scheduled to meet with a group of physician representatives on July 14 and will be reaching out to the Massachusetts Municipal Association and to Taft-Hartley plans. Finally, my efforts to schedule a meeting with private employers through the leading business coalitions have thus far proved unsuccessful, but I will make additional efforts to consult with those stakeholders.

Each of the stakeholders with whom I met readily engaged in the topic, and in most cases had strong feelings regarding the topic of price variation. With some exceptions, I asked the stakeholders three questions:

1. To what extent is price variation a problem in health care (and why)?
2. What are the drivers of price variation in health care?
3. What overarching principles should the Special Commission adopt?
4. Are there possible solutions or strategies to reduce price variation that the Special Commission should consider?

As is reflected below, the stakeholders possessed some starkly contrasting perspectives. It is important to note that this summary has not been shared with the identified stakeholder groups(s).

Community Health Centers

I met with a group of community health center executives convened at my request by the Massachusetts League of Community Health Centers. The meeting was held prior to the first Special Commission meeting. I did not ask for suggestions regarding principles for price reform.

1. To what extent is price variation a problem in health care (and why)?

    - The community health center executives identified multiple examples of price variation, including:
        - 10% higher prices for hospital-licensed health centers as compared to non-hospital licensed health centers;
        - Teaching hospital practices being paid both professional and facility fees;
        - Larger providers with better contracts than the health centers; and
        - Specialists receiving prices dramatically better than primary care physicians.
    - The participants felt that this variation was problematic for the following reasons:
        - Health centers are losing physicians to providers who can pay the physicians better. For example, one health center reported losing a physician to a Boston teaching hospital-owned practice because the hospital could pay the physician 30% more than could the health center due to the higher prices it receives.
        - Health centers cannot hire enough primary care physicians, and increasingly, cannot hire any specialists at all, needing to refer patients in need of specialty care to teaching hospitals.

2. What are the drivers of price variation in health care?

    - The community health center executives quickly identified market power and brand recognition ("the perception of quality") as the primary factors driving price variation across providers. They noted that current provider consolidation activity is making the problem worse.

3. Are there possible solutions or strategies to reduce price variation that the Special Commission should consider?

    - The meeting participants were not of one mind, and offered the following recommendations:

        - Prices should be consistent with a "same work, same pay" principle, with price variation only for quality, case mix, and socio-economic patient population status.
        - Highest paid providers should be capped or their rates of increase lowered in a regulatory fashion.
        - Regulate the extent to which insurers can vary their rates by provider.

Consumer Advocates

I met with a group of consumer advocates convened at my request by Health Care for All, consisting primarily of organization staff. The group did not have much perspective to offer on price variation,

its causes and the extent to which it is problematic. The consumer advocates did offer a number of suggestions for price reform principles, however.

1. What overarching principles should the Special Commission adopt?

    - Make price information transparent, readily accessible online and otherwise. The advocates emphasized that the information should be for consumers and not for "wonks" and that a website was not enough.
    - Address disparities in payment across service type and specialty for mental health and substance abuse service relative to other services.
    - Address the supply mix in medical education by creating prices that encourage more primary care and less specialty care.
    - Lower overall system cost.
    - Improve access and outcomes.
    - Adjust prices for quality outcomes.
    - Consider patient impact when designing and implementing strategies related to price.

<u>Health Plans</u>
I spoke via telephone with representatives of some member plans of the Massachusetts Association of Health Plans in separate interviews. I did not ask for suggestions regarding principles for price reform.

1. To what extent is price variation a problem in health care (and why)?

    - The health plan executives agreed that price variation is a problem. They reported that large and geographically dominant hospitals are paid more than other hospitals, creating differentials that don't make any sense from the plan perspective. This phenomenon is also found in the physician market and is worse than hospital price variation as large systems have focused on increasing physician compensation differentials.
    - The health plan executives felt that the identified price variation is problematic for two specific reasons.
        - Large systems with high prices "poach" physicians from other hospitals and physician groups. This practice destabilizes community hospitals.
        - Price variation has contributed to cost inflation. Providers with high prices have not been penalized for their high prices as would normally occur in a competitive market. Rather, they have been able to invest the added revenues and recruit physicians and other professionals with higher compensation thereby increasing patient volume. Conversely, low price providers have not been rewarded with increased market share.

2. What are the drivers of price variation in health care?

    - Market leverage was described as the primary driver of variation, with teaching status and provider payer mix minor considerations.
    - One health plan noted that most employee health benefit plans don't allow members to take advantage of differences in price as they can do in other markets. In health care the

member is largely shielded from realizing the economic consequences of his or her provider choice decision.

3. Are there possible solutions or strategies to reduce price variation that the Special Commission should consider?

   The following ideas came from different payers and do not represent a consensus among the interviewed health plans.

   - Prohibit physicians who don't practice on a hospital campus from billing under a hospital's tax identification number at the hospital's rates.
   - Specify that global payment rates be based on payer network averages rather than a hospital or medical group's own current reimbursement levels.
   - Support the Attorney General's "reset" proposal and address high price outliers. This would provide immediate premium relief, since premiums have grown in recent years primarily based on rate growth. This would also limit the efforts of systems to "poach" physicians from their competitors.
   - Limit how much hospitals can charge for outpatient services and physician services.
   - Prohibit physicians working in hospitals (e.g., anesthesia and radiology) and ambulances from refusing to contract with the health plan (and therefore demanding payment based on charges).
   - Modify statute and regulations issued by the Division of Insurance as a result of Chapter 288 which currently allow providers to opt out of new tiered network products.

Hospitals

I met with a group of hospital executives convened at my request by the Massachusetts Hospital Association. The hospitals included community and teaching hospitals from central and eastern Massachusetts and one major safety net hospital.

1. To what extent is price variation a problem in health care (and why)?

   - The overwhelming sentiment of these hospitals was that price variation is not a problem, and that the state's focus on price is misguided. One hospital representative noted that price variation exists in other markets and there was no reason it should not be present in health care.
   - Hospitals argued that "the only issue was the government paying its bills." One executive stated "we're underpaid for our base business – this is the issue – not commercial rates."
   - The hospitals felt they should be evaluated based on the total medical expense generated by their patient care, with appropriate adjustment for multiple factors, rather than on their prices.
   - One participant noted that it was faulty for the state to look at inpatient and outpatient prices separately, since hospitals strategically decide to price one higher relative to the other.
   - Only one hospital described price variation as an issue, but only as it pertained to physician rates and it causing Boston hospital-affiliated community physicians to

refer patients to Boston rather than to a geographically more proximate community hospital.

2. What are the drivers of price variation in health care?

   - The hospital representatives identified public payer underpayment, internal cross-subsidization, strategic positioning, and hospital costs as driving price variation.

3. What overarching principles should the Special Commission adopt?

   The participating hospitals recommended a number of principles for the Special Commission's consideration, including the following:

   - View the commercial market in the context of the broader market, i.e. recognize that pricing and hospital finances are influenced by the combined effect of private payer and public payer prices.
   - Align any recommendations with the requirements, policies and strategies of the PPACA, Group Insurance Commission, MassHealth, Connector Authority, and the Division of Insurance.
   - Engage consumers in effecting market-driven change, including through increased transparency.
   - Be sensitive to potential adverse consequences – "first do no harm."

4. Are there possible solutions or strategies to reduce price variation that the Special Commission should consider?

   - The hospitals urged the Special Commission to not focus on commercial prices, specifically recommending against rate caps.
   - The hospitals instead advocated for market-based efforts, including global payments with transparency of price, quality and consumer restrictions and tiered networks. They also restated their call for government paying its "fair share."
   - Finally, the hospital representatives emphasized that reductions in prices will mean reductions in costs, and for hospitals that will require reducing their employee count of personnel who will have difficulty finding equivalent jobs.

<u>Nurse Practitioners</u>
I spoke via telephone with representatives of the Massachusetts Coalition of Nurse Practitioners (MCNPs).

1. To what extent is price variation a problem in health care (and why)?

   - Nurse practitioners view their smaller market power as reducing the prices that they receive from insurers.
   - Nurse practitioners believe that their prices are not reflective of the quality or complexity of the services that they provide.

2. What are the drivers of price variation in health care?

   The MCNP representatives identified the following drivers of price variation:

   - The traditional practice of insurers and Medicare is to generally reimburse nurse practitioners at 85 cents on the dollar compared to physicians. The MCNP reported this practice to be in contrast to Medicaid practice where a federal rule for Medicaid managed care contracting specifies that there must be equal pay for equal services.
   - Physicians can bill as having performed a service that they did not perform, thereby getting a higher payment rate for nurse practitioner services than the nurse practitioner can earn.
   - Nurse practitioners are being tiered in insurer tiered network products for the GIC as specialists rather than as primary care providers because carriers lack enough nurse practitioner data to tier based on performance.

3. What overarching principles should the Special Commission adopt?

   The MCNP recommended the following principles for provider price reform:

   - Equal pay for equal services;
   - Nurse practitioner scope of practice to the extent permitted by state law; and
   - Prices should vary based on clinical quality outcomes data and multi-disciplinary team coordination indicators, and not on productivity benchmarks.

4. Are there possible solutions or strategies to reduce price variation that the Special Commission should consider?

   - Require by regulation that prices be negotiated based on clinical quality outcomes, and not based on consideration of quality process performance or productivity.
   - Prohibit insurer tiering of nurse practitioners as specialists.
   - Require carriers to report to the All-Payer Claims Database (administered by DHCFP) who provided services, rather than not just who billed for the care.
   - Prohibit hospital and physician group practice employers from limiting nurse practitioner scope of practice to something less than permitted by state law.

I will be holding a second round of conversations with each of the same groups following the Special Commission's third meeting to solicit reactions to the strategy options. I will then report back with stakeholder input at the Special Commission's fifth meeting.

Please feel free to contact me with any questions or suggestions, or if you should wish to attend any of the future stakeholder meetings.